HSN Billing Guideline Update

HSN Split Eligibility Billing and Use of Occurrence Codes

May 4, 2009

When providers are aware that an HSN Eligibility gap is present on a claim, the gap identification is to be reported using the Date of Exhaust occurrence code of **A3**, **B3** or **C3** and the first date of the gap period reported in the corresponding occurrence date. Occurrence codes are to be reported in Loop 2300 in the HI segment where HI01-1 = BH, HI01-2 = the occurrence code, HI01-3 = D8, and HI01-4 = the first date of the HSN Eligibility gap. This additional information will flag the claim for full eligibility checking on each day of the patient's stay, thus insuring that all services are taken into consideration for payment.

When HSN is PRIME

The use of **A3** supports that HSN is the Primary Payer (where Loop 2000B SBR01 = P, also known as the Payer Responsibility Sequence Code) on the claim and the date that follows must be within the Admit-through-Discharge period reported on the claim.

Example:
*SBR*P*18**PRIME*****ZZ~*
*HI*BH:A3:D8:20090101~*

When HSN is SECOND

The use of **B3** supports that HSN is the Secondary Payer (where Loop 2000B SBR01 = S, also known as the Payer Responsibility Sequence Code) on the claim and the date that follows must be within the Admit-through-Discharge period reported on the claim

Example:
*SBR*S*18**SECOND*****ZZ~*
*HI*BH:B3:D8:20090101~*

When HSN is TERTIARY

The use of **C3** supports that HSN is the Tertiary Payer (where Loop 2000B SBR01 = T, also known as the Payer Responsibility Sequence Code) on the claim and the date that follows must be within the Admit-through-Discharge period reported on the claim

Example:
*SBR*T*18**MH*****ZZ~*
*HI*BH:C3:D8:20090101~*

This uniform reporting allows the provider to bill other payers and use this code for them as well under their specific billing and reimbursement guidelines.

When Codes Do Not Align

If this occurrence code does not align to the HSN Payer Responsibility Sequence Code, but should, it will be ignored and may have adverse effects on the claim processing correctly. Below is an example of an incorrectly reported split for an Admit-through-Discharge of 12/31/08 through 1/10/09 where the Primary Payer denied the claim and HSN is Secondary.

Example:
*SBR*S*18**SECOND*****ZZ~*
*HI*BH:A3:D8:20090101~*

Because the occurrence code of A3 (Primary) does not align to the Payer Responsibility Sequence Code of S (Secondary) this claim may present as HSN Ineligible, thus the claim may not be flagged for payment consideration.

How to Resolve Eligibility Splits on Cycle Bills

Providers will be required to submit individual claims for pertinent Outpatient eligibility periods. An example of this would include –

> Outpatient claim submitted with a Span Date of 3/1/09 through 3/31/09. Service lines pertain to eligibility dates of 3/1 through 3/8 (two service dates within) and then on 3/24 through 3/31 (two additional service dates).

In this example, providers would need to submit four (4) Outpatient claims not designated as cycle billing (From / Thru dates would equal Service Line dates) and without an additional occurrence code and date.

Providers should note that the Division is researching moving therapy service payments to the fee schedule which would result in Outpatient Cycle Billing no longer being allowed by the HSN. The Division will inform providers once more information is made available and a decision has been reached regarding the potential fee schedule transition.

Hospitals will be paid at the transfer per diem rate for the days on which the patient was eligible, not to exceed the amount of the full DRG payment. See 114.6 CMR 14.06(2)(b)3.

Providers with any questions regarding this billing update should contact the Division's Claims Customer Support Center at (866) 697-6080 or HSNHelpLine@PublicSectorPartners.com.